Essential Physiotherapy & Wellness

Essential Physiotherapy – Contact Information

Name: _____ Occupation: _____

Address: _____City:_____Postal Code: _____

Phone: (1st Preference) _____ (2nd) _____ (3rd) _____

Family Doctor: _____ Doctor Phone/Address: _____

Date of Birth (dd/mmm/yyyy):_____ How did you hear about us? _____

IS YOUR VISIT THE RESULT OF A CAR ACCIDENT OR WORKPLACE INJURY? ☐ Yes ☐ No

Email Address: _____

By signing below you understand that Essential Physio is compliant with Anti-Spam Legislation. All email contact with you will be for the purposes of your health care such as newsletters, appointments and follow-up. _____

Medical Information Release

I,_____, hereby give permission to Essential Physiotherapy to contact and share or receive health information with my family physician, or any other health professional to determine my progress.

Signature:_____ Date:_____

Companies We Direct Bill (we will require a photocopy of your card):

☐ Greenshield ☐ Sun Life ☐ OTIP

☐ Blue Cross ☐ Great West/Canada Life ☐ Manulife

Policy #_____ Member ID # _____ Employer Name _____

(Complete if you are not the Benefit holder)
Name of Policy Holder _____ Relationship _____

Birthdate of Policy Holder _____

☐ I have benefits from a different company – Who? _____ ☐ I do not have Benefits

HEALTH CONSENT FORM (Physiotherapy)

We need your informed consent. This means that we need you to understand the services we provide, the costs, and what we do with the personal information we gather about you. Please ask us if you have any questions.

CONSENT FOR THE COLLECTION OF PERSONAL INFORMATION

I understand that to provide me with physiotherapy or massage therapy and services, Essential Physiotherapy (herein known as the company) will collect some personal information about me. (e.g., name, address, phone numbers, and health history).

I have had the opportunity to review The Company's Privacy Policy about the collection, use, and disclosure of personal information, steps taken to protect the information and my right to review my personal information. I understand how the privacy policy applies to me. I have been given a chance to ask questions I have about the privacy policies and they have been answered to my satisfaction.

I understand that, as explained in the Policies and Procedures for Personal Information, there are some rare exceptions to these commitments.

I agree to The Company collecting, using, and disclosing personal information about me as set out above and in The Company's Privacy Policy.

FEE SCHEDULE

Physiotherapy treatments in our clinic are NOT COVERED BY OHIP. Extended Health Insurance coverage for physiotherapy is provided by various companies and we advise you to determine if you have such coverage (we will be happy to provide you with invoices so you can submit to your insurance company). If you are seeking physiotherapy treatment as a result of a W.S.I.B. claim, or Motor Vehicle Accident, please advise us of such and we will initiate the appropriate billing.

However, please be advised that our contract is with you, the patient, and therefore you are ultimately responsible for payment of treatments rendered. This applies to all coverage methods (ie. Extended Health Care, W.S.I.B, and Motor Vehicle Insurance etc…). Please feel free to direct your questions to our staff. We will make every effort to assist you with your claim.

We accept Visa, MasterCard, American Express, Interac, Cheque or Cash.

	Orthopedic	Pelvic	Vestibular **
Initial Assessment	$95/$105	$120	$105
Subsequent Treatments	$75/$105/$140	$110	$80
Missed/ No Show Appointments	Full fee	Full fee	Full fee
Short Notice Cancels	50% of fee	50% of fee	50% of fee
Cancelled Appointments (with 24 Hours Notice)	No charge	No charge	No charge

*Subsequent treatment fees are based on therapist recommendations appropriate for the problems identified and will be clearly outlined prior to treatment

** Vestibular refers to patients with dizziness, vertigo, and imbalance.

See other side

INFORMED CONSENT TO PHYSIOTHERAPY TREATMENT AND CARE

In April, 1995, the Ontario Government passed the Consent to Treatment Act to safeguard the rights of people to make their own informed decisions about health treatment. The legislation requires that our therapists provide you with the necessary information on the treatment proposed so that you can make an informed choice. The purpose of this document is to outline what is involved in our physiotherapy treatment.

Depending on your needs, your program may consist of any of all of the following:

- Therapeutic exercise to restore strength and range of motion
- Electrical modalities to decrease pain and inflammation, and to promote healing
- Hands-on manual techniques to restore functional mobility and reduce pain
- Progressive strengthening and aerobic exercise to restore and maintain normal muscle strength and endurance.

Your treatment program will be designed and monitored by your physiotherapist. A Kinesiologist and/or Physiotherapist Assistant may also provide assistance in your daily care.

As in all health care, in the practice of physiotherapy, there are some risks associated with treatment, although rare. They include, but are not limited to muscle strains and sprains, fractured bones, and burns from electrical modalities.

The program is tailored to your specific stage of recovery. You may find that you are a little more stiff and sore after an initial assessment. This is because the physiotherapist must put your body through some movements that you may not normally do in order to determine the nature of the problem. Please keep the physiotherapist informed about changes in your symptoms during the course of treatment so that they can respond accordingly. We ask that you follow the therapist's instructions so that you perform the activities in a safe manner to avoid any risk of injury.

You may discontinue the treatment at any time, but we ask that you extend the courtesy of informing one of our staff of your intention to discontinue and your reasons for doing so.

If you have any further questions, you are encouraged to ask our therapists.

I have been informed of the treatment outlined above and its possible risks. I voluntarily give consent to participate in the rehabilitation program and realize that I may, at my discretion, discontinue treatment at any time. **I also understand that 24 hours notice of cancellation is expected in order to avoid billing my personal account.** By signing below, I intend this consent form to cover the entire course of treatment for my present condition.

_____ _____

Signature Date

_____

Printed Name

Notes:

E&OE

Essential Physiotherapy & Wellness

Case History Outline

Name: _____

Date: _____

Recent Condition/ Injury: Choose One other _____ Date_____

Was the onset of your current problem: Choose one

Family Doctor: _____ Age: _____ Weight: _____ Height: _____

How long have you had the problem(s)? _____

Has the condition occurred before? Choose one When? _____

Where was your original pain? _____

Has there been any radiation (spread) of your symptoms? Choose one Where? _____

Have your symptoms changed since the initial onset or injury? Choose one

Did any treatment help to relieve the symptoms? Choose one What treatment? _____

Does the condition bother you at this exact moment? Choose one

Medications (and reason): _____

_____

_____

_____

_____

Past Treatment: (Indicate how many years, months ago for past experiences)

Type (Physio, Chiro, Massage)	Date of Treatment	Results (Positive/Negative)

Past History:

Check the conditions that you experience ***frequently*** or have experienced in the past

Head/Neck:

- ☐ Headaches
  - Type _____
  - How often_____
- ☐ Vision Problems
- ☐ Contact Lenses
- ☐ Glasses
- ☐ Ear Aches

Skin:

- ☐ Sensitive skin
- ☐ Rashes, Eruptions
- ☐ Cold Sores
- ☐ Herpes
- ☐ Phlebitis
- ☐ Bruise easily
- ☐ Varicose veins
  - Date diagnosed _____

Hospitalization:

- ☐ Last Year
- ☐ 1-2 years ago
- ☐ 3-5 years ago

Digestive/ Uro-genital:

- ☐ Poor appetite
- ☐ Constipation
- ☐ Liver/Gall bladder
- ☐ Kidney/Bladder
- ☐ Difficult Digestion

Respiratory:

- ☐ Chronic cough
- ☐ Shortness of breath
- ☐ Smoking
  - ☐ Heavy
  - ☐ Light
- ☐ Pacemaker

Muscles/Joints:

- ☐ Pain
- ☐ Stiffens
- ☐ Swelling
- ☐ Limitation of movements
- ☐ Back pain
- ☐ Shoulder pain
- ☐ Neck pain
- ☐ Osteo Arthritis

Date diagnosed _____

Affected Areas _____

- ☐ Rheumatoid pain

Date diagnosed _____

Women Only:

Menstruation

Painful ☐ Heavy ○ Light ○

Pregnant

# of weeks _____

# of children_____

- ☐ Menopause

Cardiovascular:

- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Heart Disease
- ☐ Poor Circulation

Place_____

Car Accidents (Past):

- ☐ Yes, date: _____
  - Injuries Sustained: _____
  - _____
- ☐ NO

Surgery:

Name _____

Why_____

When_____

Fractures (Past):

- ☐ Yes, where_____
- ☐ Pins, plates, screws
  - _____

Other conditions:

- ☐ Sinus
- ☐ Allergies: type_____
- ☐ Colds
- ☐ AIDS/HIV
- ☐ Cancer: type _____
- ☐ Diabetes: type_____

Additional Information:

_____

_____

_____

_____

Electronic Transmission Authorization and Consent Form

(Complete if you have Benefits We Direct bill) *Instructions: This form must be filled out when claims are submitted electronically by the provider on the patient's behalf. Please retain this form in the patient's file for verification purposes for two years following closure of the patient file.*

Provider:

Essential Physiotherapy & Birth Essentials
97 Brant Ave, Brantford
N3T 3H4
(519) 752 2151

Patient: _____

Address: _____

City/Province: _____

Postal Code: _____

Phone Number: _____

Plan Number: _____

Certificate / Plan member Number: _____

Consent to Collect and Exchange Personal Information

Message to the Plan member, Spouse and/or Dependent regarding Personal Information

Personal information that we collect and disclose about you, and if applicable, your spouse and/or dependents, is used by the insurer and/or plan administrator and their service provider(s) for the purposes of assessing your claims, underwriting, investigating, auditing and administering the group benefits plan, including the investigation of fraud and / or plan abuse.

Authorization and Consent

I authorize my healthcare provider to collect, use and disclose personal information concerning any claims submitted on my behalf with the insurer and/or plan administrator and their service provider(s) for the above purposes.

I authorize the insurer and / or plan administrator and their service provider(s) to:
use my personal information for the above purposes.

Exchange personal information with any individual or organization, including healthcare professionals, investigative agencies, insurers and reinsurers, and administrators of government benefits or other benefits programs when relevant for the above purposes.

Exchange personal information concerning any claims submitted with the plan member or a person acting on behalf of the plan member. Exchange personal information for the above purposes electronically or in any other manner.

I understand that personal information may be subject to disclosure to those authorized under applicable law.

I agree that a photocopy or electronic version of this authorization shall be as valid as the original, and may remain in effect for the continued administration of the group benefits plan.

Additional Consent Applicable to Plan Members Only

I confirm that I am authorized by my spouse and/or dependents, if any, to disclose personal information about them to the insurer and/or plan administrator and their service provider(s) for the purposes described above and I confirm that my spouse and/or dependents also authorize the insurer and/or plan administrator and their service provider(s) to disclose information about their claims to me, for the purposes of assessing and paying a benefit, if any, and managing the group benefits plan. I also authorize my spouse and/or dependents to assign benefit payments under the plan to the healthcare provider.

In the event there is suspicion and/or evidence of fraud and/or plan abuse concerning claims submitted, I acknowledge and agree that the insurer and/or plan administrator and their service provider(s) may use and disclose relevant personal information to any relevant organization including law enforcement bodies, regulatory bodies, government organizations, medical suppliers and other insurers, and where applicable my Plan Sponsor, for the purposes of investigation and prevention of fraud and/or plan abuse.

If there is an overpayment, I authorize the recovery of the full amount of the overpayment from any amount payable under the group benefits plan, and the exchange of personal information with other persons or organizations, including credit agencies and, where applicable, my Plan Sponsor, for that purpose.

_____	_____	_____
Date:	Signature	Print

Benefit Assignment

I hereby assign benefits payable for the eligible claims to the Provider responsible for submitting my claims electronically to the group benefits plan and I authorize the insurer/plan administrator to issue payment directly to the Provider. In the event my claim(s) are declined by the insurer/plan administrator, I understand that I remain responsible for payment to the Provider for any services rendered and/ or supplies provided.

I acknowledge and agree that the insurer/plan administrator is under no obligation to accept this Assignment, that any benefit payment made in accordance with this Assignment will discharge the insurer/plan administrator of its obligations with respect to that benefit payment, and that in the event the benefit payment is made to me, the insurer/plan administrator will also be discharged of its obligation with respect to that benefit payment.

I understand that this Assignment will apply to all eligible claims submitted electronically by the Provider and that I may revoke it at any time by providing written notice to the insurer/plan administrator.

If I am a spouse or dependent, I confirm that I am authorized by the plan member to execute an assignment of benefit payments to the Provider.

_____	_____	_____
Date:	Signature	Print